STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155704	A. BUILDING 00 B. WING	11/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALDRON HEALTH AND REHAB CENTER	505 N MAIN ST WALDRON, IN 46182

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00119082 and IN00119144. Complaint IN00119082 Substantiated - Federal/State deficiencies related to the allegations are cited at F282 and F309. Complaint IN00119144 Substantiated - Federal/State deficiencies related to the allegations are cited at F282 and F314. Unrelated deficiency cited. Survey dates: November 14 & 15, 2012 Facility Number: 000423 Provider Number: 155704 Aim Number: 100290450 Survey Team: Mary Jane G. Fischer RN Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 20 Medicaid: 45	F0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Other: 2 Total: 67 Sample: 5 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 11/21/12 by Suzanne Williams, RN			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure the dignity of a resident, which involved inappropriate remarks by a Certified Nurses Aide [employee #6] for 1 resident in a sample of 5. [Resident "B"]. Findings include: The record for Resident "B" was reviewed on 11-14-12 at 1:10 p.m. Diagnoses included, but were not limited, to hypertension, arthritis, neuropathy, diabetes mellitus and peripheral vascular disease. These diagnoses remained current at the time of the record review. Review of the resident's Minimum Data Set assessment, dated 04-12-12 indicated the resident was not cognitively impaired, and required extensive assistance with transfer and bed mobility. Review of the resident's current plan of care, originally dated 05-16-11,	F0241	1. Resident B was assessed by nursing and found to have no adverse effects from alleged deficient practice. Certified Nurses Aide #6 was immediately taken from the floor, interviewed, and re-educated prior to working the remainder of her shift following the alleged incident. 2. All residents have the potential to be effected by the alleged deficient practice. Facility staff have been in-serviced on appropriate interactions with residents. 3. Facility staff have been inserviced on appropriate interactions with residents, resident rights, and the Abuse Prevention, Intervention, Investigation, and Crime Reporting policy. 4. Any allegations of inappropriate interactions will be reported to the Administrator or the Director of Nursing and addressed immediately with the suspected staff member. Allegations will be reviewed by the Quality Assessment and Assurance Committee for recommendations for ongoing quality improvement.	12/14/2012

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	indicated the resident was at "high risk for moderate to severe pain experience(s) r/t [related to] (diagnoses): neuropathy, cellulitis and cervical spine <sic> cord impairment." "Pain location - back, legs." A subsequent current plan of care, originally dated 05-16-11, indicated the resident had "self care deficit with bed mobility, related to weakness and neuropathy." An intervention to this plan of care included the use of a mechanical lift for all transfers. During interview on 11-15-12 at 10:25 a.m., the resident agreed to a skin assessment and during observation at 10:30 a.m., the Director of Nurses and Certified Nurses Aide employee #6, positioned the resident onto the mechanical lift and transferred the resident to bed. During this observation the resident stated to the Certified Nurse Aide, "be careful with my legs, they hurt." Once the resident was lowered to the bed, the Certified Nurse Aide started to position the resident when again the resident instructed the Certified Nurses Aide "oh be careful with my legs." The Certified Nurse Aide responded to the resident "Are you being a t--- [terminology for a bowel			

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	excrement]?" The resident did not respond. The Certified Nurse Aide then turned the resident to the left side and again the resident commented to the Certified Nurse Aide, in which the Certified Nurse Aide responded, "you turkey." The Director of Nurses instructed the employee that she would be needed to transfer the resident from bed and back into the wheelchair after a body assessment had been completed. The employee indicated she would go to lunch "now" and then be available. Once the resident was positioned comfortably in bed, the Certified Nurse Aide stated, "I'll be back later, honey." During this observation, the Director of Nurses as well as the resident's spouse, were in attendance. There was no intervention by the Director of Nurses at the time of the occurrence. During interview on 11-15-12 at 10:55 a.m., the Director of Nurses verified she heard the remarks by the Certified Nurse Aide and "I have told her to go into my office so I could talk			

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	with her." During the exit conference on 11-15-12 at 2:00 p.m., the Director of Nurses indicated the Certified Nurse Aide was "talked to" at the time of the incident, and sent to lunch. When further interviewed, the Director of Nurses indicated she interviewed three residents on the hallway in which the Certified Nurse Aide "usually worked," and had no complaints about any behavior issues with the Certified Nurse Aide. The Director of Nurses indicated she allowed the employee to return to work after lunch. Review of the employee's timecard indicated the Certified Nurses Aide "clocked out" at 10:36 a.m. and the "clocked in" at 11:08 a.m., less than 15 minutes after the interview with the Director of Nurses at 10:55 a.m. 3.1-3(t)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure the resident's plan of care and physician orders were implemented in regard to elimination and positioning needs for 2 of 5 sampled residents. [Resident's "A" and "B"]. Findings include: 1. The record for Resident "A" was reviewed on 11-14-12 at 10:35 a.m. Diagnoses included, but were not limited to, cerebral palsy, chronic constipation, history of abdominal pain, colonic ileus, diabetes mellitus and neurogenic bladder. These diagnoses remained current at the time of the record review. Further review of the record indicated the resident had hospitalizations for fecal impactions. The hospitalization dates included 08-14-2008 "severe rectal fecal impaction," a hospitalization on 08-06-12 with "additional comments" related to a diagnosis of "fecal impaction," and 10-27-12 with "primary/secondary	F0282	1. Residents A and B were assessed by nursing and found to have no adverse effects from alleged deficient practice. Their plans of care in regards to elimination and positioning have been reviewed and revised as needed.2. All residents have the potential to be effected by the alleged deficient practice. 3. Facility staff have been reinserviced on following physician's orders and the resident's plan of care.4. The Interdisciplinary Team will match CNA worksheets, Care Plans and resident position during Interdisciplinary Team Rounds to ensure that each resident is positioned and repositioned according to his or her care plan. The IDT will report results to the Quality Assessment and Assurance Committee for ongoing review and recommendations for six months. The Director of Nursing or Designee will monitor Bowel Movement Reports for correct intervention twice weekly and report results to the Quality Assessment and Assurance Committee for six months.	12/14/2012

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	diagnoses - fecal impaction, and paralytic ileus." Review of a "Major Internal Medicine" report, dated 06-26-12, indicated the resident had a recent assessment of "Clostridium difficile - plan: Continue to watch [resident] bowel pattern carefully." The the most recent Hospital "Discharge Instruction Report," dated 11-01-12 indicated "please medics <sic> and administer the MiraLax [a medication to aide in elimination] one dose prior to the initiation of tube feeds each night." "Additional Orders/Comments" included "Ideally [resident] will have 2 - 4 stools per day. If [resident] misses any day without a stool then give 2 doses of MiraLax that day. If the following day [resident] has no stool, notify physician." Review of the medication administration record for November 2012 indicated the physician order, dated 11-01-12, for MiraLax 255 gm [grams]/14 oz. [ounces] give 17 gram per gtube [gastrostomy feeding tube] mix with 4 oz. of water prn a day without stool then give a dose of MiraLax at 6:00 a.m. Resident goal is 2 - 4 soft stools per day."			

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Review of hospital "Imaging" reports, dated 05-30-12, "Indication: elevated white blood cell count, subjective abdominal complaints - Impression: severe fecal impaction., and 10-27-12 "Indication: Abdominal pain and distention - Impression: Ileus with a severe fecal impaction."

The resident's current plan of care, originally dated 10-20-08 and current as of 11-01-12, indicated "Potential for constipation/gastric distress - Dx. [diagnoses] chronic constipation, cerebral palsy health issues." The "goal" to this plan of care included "Resident will have 2 - 4 bowel movements QD [every day]." Interventions to this plan of care included "Bowel sounds prn [as needed], Report loose stools, abd. [abdominal] distention], N/V [nausea/vomiting] etc, Notify MD [Medical Doctor] as needed, Prune juice prn, Record elimination, Monitor elimination data, MiraLax QD and prn, Dulcolax supp. [suppository] as ordered, and Rezyst [a probiotic medication] as ordered."

Review of the "BM [bowel movement]" Report for the resident since the date of re-admission indicated the resident had one bowel

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	movement on 11-04-12, 11-06-12, 11-08-12, 11-09-12, 11-11-12, and 11-13-12, and had no bowel movements on 11-05-12 from 4:13 a.m. thru 11-06-12 at 8:00 p.m. when the document indicated the resident had a large bowel movement, no bowel movement from 11-09-12 at 10:33 a.m., until 11-11-12 at 4:30 a.m. and no bowel movement from 11-13-12 at 9:30 a.m. until 11-15-12 at 1:00 a.m. in which the "description" was documented as "watery large." Further review of the medication record indicated the resident received the additional dose of MiraLax at 9:31 a.m., on 11-02-12 and then again at 10:00 a.m. on 11-10-12, and not at 6:00 a.m., but the additional dose of MiraLax was not administered to the resident on 11-05-12, or on 11-09-12 when the resident had no stools. 2. The record for Resident "B" was reviewed on 11-14-12 at 1:10 p.m. Diagnoses included, but were not limited to, hypertension, arthritis, neuropathy diabetes mellitus and peripheral vascular disease. These diagnoses remained current at the time of the record review. Review of the resident's Minimum Data Set assessment, dated 04-12-12			

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	indicated the resident was not cognitively impaired, and required extensive assistance with transfer and bed mobility. A current plan of care, originally dated 05-16-11, indicated the resident had "self care deficit related to weakness and neuropathy as evidenced by extensive - to total dependent with bed mobility, transfer, dressing and toileting." The resident had recently been readmitted to the facility on 10-31-12, after a hospitalization. Review of the hospital "Discharge Instruction Report, dated 10-31-12 indicated "Wound Care Orders - BID [two times a day] apply Xenaderm to sacral area, turn Q [every] 2 hrs. [hours], use paper pads at all at all <sic> times. Use waffle mattress overlay on the bed at all times to redistribute weight due to sacral area with healing stage 2 pressure ulcer and present incontinence associated dermatitis. Pressure relief when in wheelchair also, try to limit time in wheelchair to 2 hours at a time, allow pressure relief times from the wheelchair." During observation on 11-15-12 at			

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	9:00 a.m., the resident was in room, seated in the wheelchair. During interview on 11-15-12 at 9:05 a.m., the resident's spouse indicated arrival at the facility that morning "around 7:30 a.m. and [resident] was up in the wheelchair when I got here. [Resident] complains about the sore here - motioning to the lower back - and sitting up in the wheelchair for long periods of time doesn't make it any better." During observation at 10:25 a.m., the resident remained in the wheelchair and a request was made to do a body assessment. While waiting for the facility staff to bring the mechanical lift to the resident's room, the resident indicated "I've been up in this chair since about 6:30 a.m. My bottom hurts." When interviewed if the nursing staff had attempted to check the resident for incontinence, and a change in positioning, the resident indicated "No, I haven't been changed or anything." The Director of Nurses and Certified Nurses Aide positioned the resident onto the mechanical lift and transferred the resident to bed. Registered Nurse employee #3,			

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	identified on the listing of Administrative Staff, as the wound care nurse, was requested to be in attendance during the assessment of the resident's skin. After the resident's slacks and incontinent brief were removed, stool was observed in the incontinent brief, and the sacral area was bright red and an open area was observed. This Federal tag relates to Complaints IN00119082 and IN00119144. 3.1-35(g)(2)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based interview and record review, the facility failed to ensure a resident with a history of chronic constipation and fecal impaction received treatment and ongoing nursing assessment of bowel regime for 1 of 3 residents reviewed for chronic constipation in a sample of 5. Findings include: The record for Resident "A" was reviewed on 11-14-12 at 10:35 a.m. Diagnoses included, but were not limited to, cerebral palsy, chronic constipation, history of abdominal pain, colonic ileus, diabetes mellitus and neurogenic bladder. These diagnoses remained current at the time of the record review. Review of a "Major Internal Medicine" report, dated 06-26-12, indicated the resident had a recent assessment of "Clostridium difficile - plan: Continue to watch [resident] bowel pattern carefully."	F0309	1. Resident A was assessed by nursing and found to have no adverse effects from alleged deficient practice. His bowel regimen was assessed and modified by his primary healthcare provider. 2. All residents have the potential to be effected by the alleged deficient practice. 3. Facility nursing staff have been reinserviced on bowel management practices. 4. The Director of Nursing or Designee will monitor Bowel Movement Reports for correct intervention twice weekly and report results to the Quality Assessment and Assurance Committee for six months.	12/14/2012

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	Further review of the record indicated the resident had hospitalizations for fecal impactions. The hospitalization dates included 08-14-2008 "severe rectal fecal impaction," a hospitalization on 08-06-12, with "additional comments related to a diagnosis of "fecal impaction," and 10-27-12, with "primary/secondary diagnoses - fecal impaction, and paralytic ileus." Review of hospital "Imaging" reports dated 05-30-12, "Indication: elevated white blood cell count, subjective abdominal complaints - Impression: severe fecal impaction., and 10-27-12 "Indication: Abdominal pain and distention - Impression: Ileus with a severe fecal impaction." The resident's current plan of care, originally dated 10-20-08 and current as of 11-01-12, indicated "Potential for constipation/gastric distress - Dx. [diagnoses] chronic constipation, cerebral palsy health issues." The "goal" to this plan of care included "Resident will have 2 - 4 bowel movements QD [every day]." Interventions to this plan of care included "Bowel sounds prn [as needed], Report loose stools, abd. [abdominal] distention], N/V			

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	[nausea/vomiting] etc, Notify MD [Medical Doctor] as needed, Prune juice prn, Record elimination, Monitor elimination data, MiraLax QD and prn, Dulcolax supp. [suppository] as ordered, and Rezyst [a probiotic medication] as ordered." Review of the "BM [bowel movement] Report," for August and September 2012 indicated the resident had no bowel movement from 08-30-12 at 9:40 a.m. until 09-04-12 at 7:55 p.m., 09-23-12 at 7:44 a.m. through 09-30-12 when the document indicated the resident had a medium bowel movement at 10:18 a.m., and then did not have another bowel movement from the time of the medium bowel movement recorded on 09-30-12 until 10-06-12 at 10:17 a.m., when the resident had a "large" bowel movement. Review of an "alert report" indicated that on "09-02-12 at 4:00 p.m. - last valid BM was 3 days and 6 hours ago on Aug. [August] 30 9:40 a.m. - Resolution - resolved 09-08-12 [9 days] at 1:37 p.m. had lg [large] bm." When interviewed on 11/15/12 at 12:50 p.m., regarding what interventions were attempted for the resident's bowel regime, the Director of Nurses indicated, "I don't have			

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	155704	A. BUILDING 00 B. WING	11/15/2012

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	anything else to give you for this one; I don't know what was done." A subsequent "alert report" dated 09-26-12 at 8:00 a.m., indicated "last valid BM was 3 days ago, on Sep. [September] 23 at 7:44 a.m. - Resolution - resolved will give PRN or prune juice." During interview on 11-15-12 at 12:50 p.m., the Director of Nurses indicated "I don't know what she [in regard to the licensed nurse] gave to the resident." The nurses notes, dated 10-27-12 at 8:44 a.m., indicated "noted resident gagging and having hiccups - resident stating 'mom' and crying out off and on which started on: <sic> asked resident if happened during the night and [resident] said 'yes.' Asked if it happened yesterday and [resident] said 'no.' Did insert GT [gastrostomy feeding tube] to let out air, large amount of air was removed. Bowel sounds hyperactive. Last BM today this a.m." Review of the October 2012 BM record indicated the resident had a "small" bowel movement on 10-27-12 at 7:51 a.m. The resident was transported to the local hospital emergency room on			

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	10-27-12 at 9:30 a.m. Review of the emergency room report indicated "[resident] here with abdominal pain, family reports receiving call from Waldron Rehab. reporting pt. [patient] c/o [complains of] diffuse abdominal pain, with gagging sensation. Pt unable to describe or rate pain 2/2 [secondary] to chronic illness. Family reports pt has history of ileus in the past and is concerned about possible recurrence. ED [emergency department] course: fecal impaction with obstruction. Disimpaction 25 mcg [micrograms] fentanyl [pain medication] given. Soft stool in finger grasp. Larege <sic> amount felt distally to finger tip. Unable to obtain. Will attemp <sic> soap sud <sic> enema. Re-exam: Watery return. Small BM. Attempted 2nd disimpaction: small amount of soft stool. Clinical Impression 1. Fecal impaction, 2. Acute Abdominal Pain." The hospital Imagining Report dated 10-27-12 indicated the resident had a "severe fecal impaction." A "surgical consultation" was ordered and the the report dated 10-29-12 indicated, "I was asked by the hospitalist service to see this patient.			

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	The patient is a [description of resident] with severe cerebral palsy. The patient was admitted because [resident] could not go to the restroom. A CT scan was performed that showed a large fecal ball." The hospital "History and Physical" report dated 10-28-12 also indicated "the fecal ball is quite large and [resident] is having difficulty passing it. General surgery has been consulted and may have to intervene." The hospital "Physician Progress Note," dated 10-30-12 indicated the resident had "surgery performed aggressive disimpaction." The resident was re-admitted to the facility on 11-01-12. Review of the "Discharge Instruction Report," dated 11-01-12, indicated "please medics <sic> and administer the MiraLax [a medication to aide in elimination] one dose prior to the initiation of tube feeds each night." "Additional Orders/Comments" included "Ideally [resident] will have 2 - 4 stools per day. If [resident] misses any day without a stool then give 2 doses of MiraLax that day. If the following day [resident] has no stool,			

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	notify physician." Review of the medication administration record for November 2012 indicated the physician order dated 11-01-12 for MiraLax 255 gm [grams]/14 oz. [ounces] give 17 gram per gtube [gastrostomy feeding tube] mix with 4 oz. of water prn a day without stool then give a dose of MiraLax at 6:00 a.m. Resident goal is 2 - 4 soft stools per day." Review of the "BM [bowel movement]" Report for the resident since the date of re-admission indicated the resident had one bowel movement on 11-04-12, 11-06-12, 11-08-12, 11-09-12, 11-11-12, and 11-13-12, and had no bowel movements on 11-05-12 from 4:13 a.m. thru 11-06-12 at 8:00 p.m. when the document indicated the resident had a large bowel movement, no bowel movement from 11-09-12 at 10:33 a.m., until 11-11-12 at 4:30 a.m. and no bowel movement from 11-13-12 at 9:30 a.m. until 11-15-12 at 1:00 a.m. in which the "description" was documented as "watery large." Further review of the medication record indicated the resident received the additional dose of MiraLax at 9:31 a.m., on 11-02-12 and then again at			

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	10:00 a.m. on 11-10-12, and not at 6:00 a.m., but the additional dose of MiraLax was not administered to the resident on 11-05-12, or on 11-09-12 when the resident had no stools. Review of the facility "Bowel Movement Regulation," policy on 11-15-12 at 12:30 p.m., indicated the following: "PURPOSE: To help prevent constipation or fecal impaction. * Nursing to document occurrence and size of bowel movement daily. * Licensed nurse will review documentation daily. * If resident has had no documentation of bowel movement for two days, then prune juice will be offered. * If resident has no documentation for three days, then laxative will be given." This Federal tag relates to Complaint IN00119082. 3.1-37(a)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure a dependent resident received treatment and services to promote healing and prevent new sores from developing by implementing repositioning and incontinent needs, for 1 of 3 residents reviewed for pressure ulcers in a sample of 5. [Resident "B"] Findings include: The record for Resident "B" was reviewed on 11-14-12 at 1:10 p.m. Diagnoses included but were not limited to hypertension, arthritis, neuropathy diabetes mellitus and peripheral vascular disease. These diagnoses remained current at the time of the record review. Review of the resident's Minimum	F0314	1. Resident B was assessed by nursing and found to have no adverse effects from alleged deficient practice. Resident B continues to have incontinent dermatitis from stool leakage. His repositioning schedule has been reviewed and revised to a schedule of his agreement.2. All residents have the potential to be effected by the alleged deficient practice.3. Facility nursing staff inserviced on reposition schedules and incontinent care timing. 4. The Interdisciplinary Team will match CNA worksheets, Care Plans and resident position during Interdisciplinary Team Rounds to ensure that each resident is positioned and repositioned according to his or her care plan. The IDT will report results to the Quality Assessment and Assurance Committee for ongoing review and recommendations for six months.	12/14/2012

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	Data Set assessment, dated 04-12-12 indicated the resident was not cognitively impaired, required extensive assistance with transfer, bed mobility, hygiene, toileting and was frequently incontinent of bowel and bladder. A current plan of care, originally dated 05-16-11, indicated the resident had "self care deficit related to weakness and neuropathy as evidenced by extensive - to total dependent with bed mobility, transfer, dressing and toileting." A subsequent current plan of care, originally dated 05-16-11, indicated the resident had the "potential for impaired skin integrity related to "requires assistance with turning and repositioning, impaired mobility, and incontinent of bowels [wears briefs]." Interventions to this plan of care included "pressure reducing mattress to bed, pressure reducing cushion to w/c [wheelchair], Xenaderm ointment as ordered." The resident had recently been readmitted to the facility on 10-31-12, after a hospitalization. Review of the hospital "Discharge Instruction Report" dated 10-31-12,			

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	indicated "Wound Care Orders - BID [two times a day] apply Xenaderm to sacral area, turn Q [every] 2 hrs. [hours], use paper pads at all at all <sic> times. Use waffle mattress overlay on the bed at all times to redistribute weight due to sacral area with healing stage 2 pressure ulcer and present incontinence associated dermatitis. Pressure relief when in wheelchair also, try to limit time in wheelchair to 2 hours at a time, allow pressure relief times from the wheelchair." During observation on 11-15-12 at 9:00 a.m., the resident was in room, seated in the wheelchair. During interview on 11-15-12 at 9:05 a.m., the resident's spouse indicated arrival at the facility that morning "around 7:30 a.m. and [resident] was up in the wheelchair when I got here. [Resident] complains about the sore here - motioning to the lower back - and sitting up in the wheelchair for long periods of time doesn't make it any better." During observation at 10:25 a.m., the resident remained in the wheelchair and a request was made to do a body assessment. While waiting for the facility staff to bring the mechanical lift			

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	to the resident's room, the resident indicated "I've been up in this chair since about 6:30 [a.m.] this morning, my bottom hurts." When interviewed if the nursing staff had attempted to check the resident for incontinence, and a change in positioning, the resident indicated "No, I haven't been changed or anything." During this observation, the resident placed right had on the hand rest of the wheelchair, pushing self in an upward direction. When interviewed if [resident] sacral area was sore, the resident indicated "yes." The Certified Nurses Aide brought the mechanical lift into the resident's room, and the Director of Nurses and Certified Nurses Aide positioned the resident onto the mechanical lift and transferred the resident to bed. Registered Nurse employee #3, identified on the listing of Administrative Staff, as the wound care nurse, was requested to be in attendance during the assessment of the resident's skin. After the resident's slacks and incontinent brief were removed, stool was observed in the incontinent brief, and along the edges of the reddened			

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	area of the sacrum. The resident's sacral area was bright red in appearance and an open area was also observed. The measurements of the reddened sacral area, by the wound care nurse were "6.0 centimeters in width by 9.0 centimeters in length," with an additional reddened area in the fold of the right buttocks, which measured "5.0 centimeters by 4.0 centimeters," and a small open area located on the right upper section of the reddened area and described by the wound care nurse as a "slit" which measured ".5 centimeters by .1 centimeters." During this observation the wound care nurse indicated the resident had "constant stool," and "that is what caused the irritation [redness] to the dermatitis." The wound care nurse further indicated "the hospital identified that reddened area as dermatitis and [resident] did not have a pressure ulcer." During interview on 11-15-12 at 1:35 p.m., the hospital record was reviewed with the wound nurse and the Director of Nurses, and the wound nurse indicated she was unaware the resident had a pressure ulcer while in the hospital.			

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